Arizona Breast Consultants

Date _____

Patient _____ DOB _____

Please complete ENTIRE form. Mark "N/A" for areas that do not pertain to you

Internist/Family Doctor _____

OB/Gynecologist _____

Chief Complaint/Concerns _____

First Noticed _____ Severity or size _____

Possible Causes (stress, medications, menstrual cycle) _____

Medication Allergies	Reaction

Current Prescribed Medications and Dosage

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____

Medical Condition History – Please CHECK ALL that apply

[ ] Anemia
[ ] Anxiety and Depression
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disorder
[ ] BRCA Positive/Negative
[ ] Clotting
[ ] Depression
[ ] Diabetes
[ ] Emphysema
[ ] Excessive Bleeding
[ ] Heart Attack (MI)
[ ] Heart Problems
[ ] Heart Surgery
[ ] Hepatitis or Jaundice
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] HIV or AIDS
[ ] Kidney Problems
[ ] Stroke
[ ] TB (Tuberculosis)
[ ] Thyroid Disease
[ ] Ulcers

[ ] Cancer – Type/Year Diagnosed _____

Family History of Breast Cancer

Please list APPROXIMATE AGE of diagnosis.

First Degree Relatives: Self _____ Mother _____ Sister(s) _____ Daughter(s) _____

Maternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____

Paternal Side: Grandmother _____ Aunt(s) _____ Cousin(s) _____ Men _____

BRCA Positive: Mother _____ Sister(s) _____ Daughter(s) _____ Grandmother(s) _____ Aunt(s) _____

Family History *(First Degree Relatives ONLY – Parents, Siblings, Offspring)*

Has anyone in your family had any of the following? List family member & current age or age deceased.

Cancer – List Type _____

Diabetes _____

Heart Attack _____

Heart Failure _____

High Blood Pressure _____

Stroke _____

Social History

Do you currently use tobacco products? _____ Packs daily? _____ How long? _____ Former user? _____

Do you drink caffeine? _____ Servings per day: Coffee _____ Tea _____ Cola _____

Do you drink alcohol? _____ Type _____ How often? _____

Is there any history of illegal drug use? _____ **This information is strictly confidential and is for medical purposes only**

Female History

Age Menstrual Cycle Began _____ Date of Last Menstrual Period _____ Menopause Age _____

Age at delivery of first live child _____ Pregnancies (How many?) _____ Number of Children - Boys _____ Girls _____

Are you taking hormones? ____ Have you in the past? ____ What kind? _____ Date Stopped _____

Past Surgical History

Please indicate side. (Right, Left, or Both)

Procedure/Surgery	Condition	Year

Preferred Pharmacy _____

Pharmacy Cross Streets _____

□ **NEW PATIENT REGISTRATION** **EIN 20-1505116**

ARIZONA ASSOCIATED SURGEONS, PLLC

□ **Allen Agapay, MD** □ **Ravia Bokhari, MD** □ **Jeromy S. Brink, MD** □ **Charles Castillo, MD** □ **Adrienne Forstner-Barthell, MD**
□ **Tracy Freeborn, DO** □ **William Friese, MD** □ **Jordan Glenn, DO** □ **Richard Harding, MD** □ **David Johnson, MD**
□ **Jon King, MD** □ **Jennifer O'Neill, MD** □ **Mary Schultheis, MD** □ **Brett Siegrist, MD** □ **David Smith, MD** □ **Keith Zacher, MD**

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP	SEX: □ MALE □ FEMALE

HOME PHONE	CELL PHONE	EMAIL	MARITAL STATUS: □ MARRIED □ SINGLE □ WIDOWED □ DIVORCED □ OTHER

REFERRING PHYSICIAN	PHONE NUMBER
PRIMARY CARE PHYSICIAN	PHONE NUMBER

HOW DID YOU HEAR ABOUT US: □ PROVIDER REFERRAL □ INTERNET □ WORD OF MOUTH □ PREVIOUS PATIENT □ CURRENT PATIENT
□ BROCHURE □ INSURANCE □ HOSPITAL □ CONCENTRA □ MAGAZINE □ RADIO □ OTHER _____

MANDATORY-PER NEW CMS GUIDELINES

LANGUAGE	**ETHNICITY**	**RACE**
□ ENGLISH □ SPANISH □ OTHER _____	□ LATINO/HISPANIC □ NON LATINO/NON HISPANIC	□ AMERICAN INDIAN □ ALASKA NATIVE □ ASIAN □ BLACK/AFRICAN AMERICAN □ NATIVE HAWAIIAN □ OTHER PACIFIC ISLANDER □ WHITE/CAUCASION □ REFUSE TO REPORT

RESPONSIBLE PARTY INFORMATION (FINANCIAL RESPONSIBILITY)

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	HOME PHONE

EMPLOYER	OCCUPATION	WORK PHONE

EMPLOYER ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY □ SELF □ SPOUSE □ CHILD □ OTHER

EMERGENCY INFORMATION

NEXT-OF-KIN	RELATIONSHIP	PHONE

INSURANCE INFORMATION-SUBSCRIBER PARTY INFORMATION

PRIMARY INSURANCE	**SUBSCRIBER NAME**	DATE OF BIRTH

MEMBER ID	GROUP NUMBER	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE

SECONDARY INSURANCE	**SUBSCRIBER NAME**	DATE OF BIRTH

MEMBER ID	GROUP NUMBER	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

ASSIGNMENT OF BENEFITS, FINANCIAL POLICY TERMS, AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS

I have read, understand, agree to, and signed the Arizona Associated Surgeons Financial Policy. I understand and agree that I will be responsible for any unpaid balances for any reasons**.**

I hereby authorize direct payment to Arizona Associated Surgeons PLLC of any medical benefits payable to me for the services provided at Arizona Associated Surgeons.

X_____ _____
Patient Signature or Legally Authorized Individual Signature Date

RECORDS RELEASE

I hereby authorize Arizona Associated Surgeons PLLC to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor.

X_____ _____
Patient Signature or Legally Authorized Individual Signature Date

RELEASE OF HEALTH INFORMATION & DISCLOSURE FORM

PATIENT _____ **Date of Birth** _____

I hereby authorize Jennifer O'Neill, MD to release and disclose my protected health information to the individuals listed below. I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Arizona Associated Surgeons.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

☐ **DO NOT** speak to any individual on my behalf _____
(Initials)

My preferred method of contact:

☐ Cell Phone: _____

Initial One _____ Permission to leave a detailed message

_____ **DO NOT** leave a detailed message

☐ Voicemail: _____

Initial One _____ Permission to leave a detailed message

_____ **DO NOT** leave a detailed message

☐ Email: _____

_____ _____
Patient or Legally Authorized Individual Signature Date

_____ _____
Printed Name if Signed on Behalf of the Patient Relationship to Patient

OFFICE & FINANCIAL POLICIES

Thank you for choosing Arizona Breast Consultants a division of Arizona Associated Surgeons for your surgical needs. Our primary goal is to provide you with the highest quality medical care and maintaining a good physician-patient relationship. We are committed to meet this goal with effective communication and making you aware of our office and financial policies in advance. We realize you have choices for your medical care and appreciate you choosing our practice.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card(s) and Social Security number to enable us to submit your claims timely and accurately
- Knowing your insurance benefits and limitations
- Obtaining a written referral and/or authorization for our providers to treat you **IF** required by your insurance
- Providing us with copies of any pertinent medical records including tests and x-rays
- Paying your estimated portion of the charges at the time of service and paying any additional amount owed when due
- Copays are subject to $25 surcharge if not paid at time of service
- Providing us with at least 24 hours (1 business day) advanced notice should you need to cancel or reschedule an appointment to avoid no show fees which are not billable to insurance
- Arriving on time – patients will be rescheduled if more than 15 minutes late to scheduled appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

For our patient's convenience we participate in most major health plans and have contracts with many HMO's, PPO's, insurance companies and government agencies including Medicare and Medicaid (AHCCCS). Our business office will submit claims for services rendered to a patient who is a member of one of these plans and assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information at the time the appointment is scheduled. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If you are insured by a plan we contract with but don't have an insurance card with you, payment in full for each visit is required until you furnish us with a copy of the card and your coverage can be verified.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion on date of service

Your insurance company requires us to collect co-payments at time of service. Waiver of co-payments may constitute fraud under state and federal law. For your convenience we accept cash, checks or the following credit cards: Visa, Master Card, Discover and American Express. If you do not have your co-payment your appointment may be rescheduled. Additionally, you may have co- insurance and/or deductible amounts due as required by your insurance carrier.

Surgery

If surgery is indicated, our office will collect as a pre-payment any remaining deductible you may have and any co-insurance due prior to your surgery. Your out of pocket cost is estimated based on your benefits and our fees. Anesthesia, facility and other providers are separate fees. If your remaining deductible is not applied to our claim by your insurance company, a credit will appear on your account and a refund will be promptly processed and mailed to you.

Other Charges

No Show - Please provide us with at least 24 hours (1 business day) advanced notice if you need to cancel or reschedule an appointment, procedure/surgery. Failure to cancel a scheduled appointment may be subject to a $50.00 fee and failure to cancel a surgery/procedure may be subject to a $250.00 fee.

Forms - There is a $25.00 fee for forms (i.e. FMLA, Disability) our office is requested to complete. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow 7 - 10 business days for completion.

Payment

Payment Options - We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated checks or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts - We allow 30 days from date of filing for an insurance company to process and/or pay a claim. Arizona law allows insurance companies operating in the state no more than 30 days to process claims. It is your responsibility to provide your insurance company with requested information needed to process a claim. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional services. Patient balances are billed immediately on receipt of your insurance company payment or receipt of Explanation of Benefits (EOB). Your remittance is due within 10 business days of your receipt of your bill.

Alternative Payment Arrangements - If you are unable to pay your balance when due, please contact our business office at 602-258- 9900, option 1, to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid in full or the patient is complying with an alternative payment arrangement.

Prior Bad Debt – Patients who have never satisfied their payment obligations for prior episodes of care with Arizona Associated Surgeons, will be required to pay those in full before receiving additional care.

Acknowledgement of Receipt of Arizona Breast Consultants Office and Financial Policies

I have read and understand the office and financial policies and agree to comply and accept the responsibility for any payment that becomes due as outlined in the copy provided to me for my reference.

Please initial to acknowledge that you have read our financial policy, which reflects that you as the patient are ultimately responsible for the charges associated with your care. Initial: _____

Please initial to acknowledge that you are aware of our appointment cancelation/no-show policy which states:

If 48-hour notice is not given prior to an office appointment, you will be charged a $50 fee. Initial: _____

If 72 hour notice is not given prior to a scheduled surgery, you will be charged a $250 fee. Initial: _____

Patient Name	Date of Birth
Patient or Legally Authorized Individual Signature	Date
Printed Name if Signed on Behalf of the Patient	Relationship to Patient
Staff Signature	Date

Acknowledgement of Receipt of Privacy Notice and Health Information Notice

I acknowledge that I have been provided the Arizona Associated Surgeons, PLLC ("Practice") Notice of Privacy Practices and Notice of Health Information Practices ("Notice"):

- It tells me how the Practice will use my health information for the purposes of my treatment, payment for my treatment, and the Practice's health care operations.
- The notice explains in more detail how the Practice may use and share my information for other than treatment, payment, and healthcare operations.
- The practice will also use and share my health information as required/permitted by law.
- It tells me how the Practice will electronically share health information with the Health Information Organization (HIO).
- The notice explains in more detail how I may opt out of sharing my health information with the HIO.

Patient or Legally Authorized Individual Signature

Date

Printed Name if Signed on Behalf of the Patient

Relationship to Patient